STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285249	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Joseph's Villa, Inc.	927 Seventh Street David City, NE 68632

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45484 Licensure Reference Number 175 NAC 12-006.02(H) Based on record reviews and interviews, the facility failed to report a fall resulting in serious bodily injury to the state agency within the required time frame for 2 residents (Resident 1 and Resident 4) of 3 residents sampled, and the facility failed to ensure the written investigations were submitted within five working days for 2 residents (Resident 1 and Resident 2) of 3 residents sampled. The facility census was 54. Findings are: A record review of the facility's Abuse, Neglect and Exploitation policy dated 03/21/2024 revealed that facility procedures include reporting of all alleged violations to the state agency and/or Adult Protective Services (APS) immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. Further review of the policy revealed the Administrator would report the results of the investigation when final within 5 working days of the incident, as required by state agencies. A. A record review of Resident 1's Admission Record printed 09/26/2024 revealed the resident was admitted on [DATE] and had a primary diagnosis of multiple sclerosis (a disorder of the central nervous system marked by weakness, numbness, a loss of muscle coordination, and problems with vision, speech, and bladder control) and a diagnosis of quadriplegia (a partial or complete inability to move both arms and both legs). A record review of Resident 1's Progress Notes revealed a note dated 09/03/2024 at 5:06 AM that stated the resident had fallen and was complaining of left shoulder pain. Resident 1 was sent to the emergency room (ER) by ambulance to be evaluated. Further review of the Progress Notes revealed a note dated 09/03/2024 at 8:41 AM that stated the resident had returned with orders to Keep left shoulder immobilizer and sling on at all times until follow up with [orthopedic surgeon]. Record review of a Progress Note dated 09/04/2024 at 11:51 AM addressing the fall on 09/03/2024 revealed Resident 1 was sent to ER for x-rays and later returned with results of a fracture. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the facility Investigation Report for this fall revealed the incident was not reported to APS until 09/03/2024 at 5:00 PM. Further review revealed the Investigation Report was not sent to the state agency until 09/18/2024. An interview on 09/26/2024 at 4:55 PM with the Administrative Trainee (AT) confirmed the fall resulting in a fracture was not reported to the state agency within the required time frame, and further confirmed that the investigative report was not submitted within five working days of the incident. B. A record review of Resident 4s Admission Record printed 09/26/2024 revealed the resident was admitted on [DATE] and had a primary diagnosis of dementia (a term for several diseases that affect memory, thinking, and the ability to perform daily activities). A record review of Resident 4'sProgress Notes revealed no documentation of the resident's fall on 09/15/2024. Review of a Progress Note dated 09/16/2024 at 5:49 AM revealed the resident was complaining of shoulder pain and that paperwork was ready for transportation to make an appointment. Further review of the Progress Notes revealed the resident left for an appointment on 09/16/2024 at 2:23 PM and returned to the facility on [DATE] at 4:47 PM with a diagnosis of a fractured right clavicle (collarbone). Review of a Progress Note dated 09/17/2024 at 5:19 PM stated the resident had a fall on 09/15/2024 and sustained a right clavicle fracture. A record review of the facility Investigation Report for this fall revealed the incident was not reported to APS until 09/19/2024. No time was listed on the report. An interview on 09/26/2024 at 4:55 PM with the AT confirmed the fall resulting in a fracture was not reported to the state agency within the required time frame. C. A record review of Resident 2's Admission Record printed 09/26/2024 revealed the resident was admitted [DATE] and had a primary diagnosis of Alzheimer's disease (a form of dementia), and a diagnosis of Down Syndrome (a genetic disorder resulting developmental delays, and mental and physical challenges). A record review of Resident 2's Progress Notes revealed a note dated 09/06/2024 at 9:52 AM that stated the resident had fallen at 7:15 AM and received a laceration to the right side of the face. The resident had gone to the ER and returned to the facility at 9:50 AM with sutures. Further review revealed a Progress Note dated 09/09/2024 at 12:39 that addressed the fall with laceration received on 09/06/2024. A record review of the facility Investigation Report for this fall revealed the Investigation Report was not sent to the state agency until 09/18/2024 at 5:00 PM. An interview on 09/26/2024 at 4:55 PM with the AT confirmed that the investigative report was not submitted within five working days of the incident.